STATE PERSONNEL BOARD, STATE OF COLORADO
Case No. **2003B099**

INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE

LEON ARAGON,

Complainant,

vs.

DEPARTMENT OF HUMAN SERVICES, COLORADO MENTAL HEALTH INSTITUTE AT PUEBL0,

Respondent.

Administrative Law Judge Mary S. McClatchey held the hearing in this matter on June 17, 18, 23 and 25, 2003, at the State Personnel Board, 1120 Lincoln, Suite 1420, Denver, Colorado. Mark Gerganoff, Frank & Finger, P.C., represented Complainant Leon Aragon ("Complainant" or "Aragon"). Assistant Attorney General Luis Corchado represented Respondent Department of Human Services, Colorado Mental Health Institute at Pueblo ("Respondent" or "CMHIP").

MATTER APPEALED

Complainant appeals his disciplinary termination by Respondent and seeks reinstatement, back pay, and attorney fees and costs.

For the reasons set forth below, Respondent's action is **affirmed**.

PROCEDURAL MATTERS

On May 29, 2003, the Administrative Law Judge entered a Protective Order concerning Protected Health Information. Pursuant to that Order, exhibits containing identifying information regarding CMHIP patients are under seal.

ISSUES

1. Whether Complainant committed the acts for which he was disciplined;

2. Whether Respondent's action was arbitrary, capricious or contrary to rule or law;

3. Whether Complainant is entitled to an award of attorney fees and costs.

FINDINGS OF FACT

1. Leon Aragon commenced employment at CMHIP in July 1981 as a Psychiatric Technician I. In 1991 he became a Psychiatric Technician II.

2. The basic function of CMHIP is to provide evaluation and treatment for mentally ill individuals. The hospital contains three treatment divisions, one of which is the Institute for Forensic Psychiatry ("IFP"), which houses individuals 18 years and older that have been committed for psychiatric illness in concurrence with the commission of a crime. Many individuals committed to IFP have been adjudicated Not Guilty by Reason of Insanity ("NGRI"), meaning they were found to have committed crimes in a court of law, but were then sent to CMHIP for evaluation and treatment in lieu of prison. Most NGRI patients at CMHIP have committed violent crimes.

3. The treatment goals for forensic patients are to diminish symptoms and remediate the behaviors of the mental illness, to increase the patient's understanding of his or her mental illness, and to provide treatment to enhance coping skills, with the ultimate goal of having the patient return to society.

4. The IFP treatment model utilizes a four-stage security continuum. The security levels on the wards are: maximum, medium, intermediate, and minimum.

5. Aragon has worked on a number of different wards at CMHIP.

6. Aragon is 5'5" tall and weighs approximately 190 pounds.

CMHIP Staff Training

7. CMHIP provides mandatory training to all staff in how to assess and deal with patients that become aggressive or violent. Prior to working on the wards with the patients, all staff, including police officers, nurses, Psychiatric Technicians, and others, must pass the training courses. The staff training described below constitutes professional standards of performance and conduct that all CMHIP employees are expected to follow. Aragon received the training and did well in it.

8. The staff training is generally referred to as "CTI," which stands for Continuum of Therapeutic Interventions, and consists of two parts: Verbal Judo, and Escapes and Physical Control Techniques.

Assessing Danger to Avoid Conflict Situations; Circle of Proxemics; Verbal Judo

9. Staff are taught about proxemics, which is the study of how people use and structure space. Staff are taught to visualize four concentric rings around them, with the ring closest to their body representing the highest level of danger. The Green zone, starting 21 feet from the staff person and extending outward, is generally considered a safe zone. The Yellow zone, 15 - 20 feet from a staff person, is where staff "must begin to observe and be aware of anyone entering this area." The Orange zone, 5 - 15 feet from a staff person, is where "any person entering this zone must be assessed as either a threat or non-threat."

10. The Red zone, the "personal danger zone," extends from a staff member's person out to five feet. "The moment anyone threatening to you enters this zone, you need to act - verbally first and physically if equal or greater resistance is met."

11. Staff are to avoid close physical proximity to a patient deemed not to be safe.

12. If a patient shows signs of agitation, staff must attempt to verbally de-escalate the situation prior to taking any physical action. Verbal de-escalation is achieved by using Verbal Judo, which consists of 8 tactical steps: assess; greeting; identify self and position; reason; ask; forecast; decision; close.

13. Verbal Judo Step 1, Assess, states, "Take a look at your surroundings. Don't be drawn into an unsafe situation or environment. Your focus is directed and immediately followed by . . . [the next steps]."

14. Staff are trained to "be aware of the ward surroundings, to constantly assess the situation. If a patient approaches, where are his hands? What does the body language tell you? Is he making eye contact?"

15. Staff are taught that if a patient is engaging in verbal aggression, do not take it personally, do not get drawn into a verbal altercation.

16. Staff are to use proxemics and verbal judo to constantly assess potential danger on the wards at CMHIP. In addition, they are to constantly communicate with other staff to assure their own and the patients' safety.

Deflection and Redirection

17. Staff are taught to try to deflect and redirect a patient attempting to punch them, by pivoting around the aggressor while allowing the aggressor to move forward. Then, the staff member is to position himself or herself behind the aggressor and call for help.

Physical Intervention with a Patient

18. The fundamental rules governing physical intervention with a patient are:

A. Never handle an out-of-control patient alone. A one-on-one physical altercation is the most likely to cause injury to patient and staff member;

B. Always call for help immediately, in order to increase the ratio of staff to patient and thereby reduce the risk of injury. Often, the presence of additional staff can stop a patient from acting on his or her aggression;

C. Always use the least amount of physical force possible in any situation. If force must be used with a patient, "it must be reasonable, appropriate, necessary, least restrictive, justifiable";

D. If attacked by a patient when alone, the first priority is to run away.

Protective Restraint Technique.

19. Protective Restraint Techniques ("PRT's") are the accepted means by which staff are permitted to physically restrain patients. The accepted method involves positioning oneself behind the patient and gaining control of his or her arms behind his or her body.

20. The One-Person Protective Restraint Technique training states as follows: "Team restraint is always preferable. If an aggressor is larger than you or stronger or you believe there is a possibility of injury to you or the aggressor, do not attempt this technique. . . Use all available resources to obtain additional help."

21. Employees are informed during the training that failure to use the physical restraint techniques taught in the training may result in termination.

Patient R.L.

22. R.L. is a 49-year old forensic patient who, in January 2003, resided on Ward F-5, an intermediate level security ward at CMHIP. He is 5' 7" tall and weighs approximately 120 pounds.

23. Aragon has worked with R.L. for over twenty years and knows him well. Prior to January 31, 2003, Aragon had always had a very strong therapeutic relationship and rapport with R.L. They played cards, pool, and other games together often.

24. R.L. has a diagnosis of paranoid schizophrenia and, without medication, has auditory hallucinations. R.L.'s mental condition has been generally stable for a period of years due to successful medication of his condition.

25. R.L. has been assaultive with other patients and staff at CMHIP in the past. This is common knowledge to staff including Aragon.

26. In early January 2003, R.L.'s mother passed away. She had been his primary visitor, his

main source of personal support. Her death was devastating to R.L.

27. After his mother's death, R.L. decompensated, meaning that the symptoms of his mental illness repeatedly re-surfaced and became more difficult to control with the standard medication.

28. Throughout mid- and late-January 2003, R.L. suffered an increase in auditory hallucinations and repeatedly requested extra medication to control them. By late January, this occurred more than once a day.

29. Ward F-5 staff, including Aragon, knew that R.L.'s condition had significantly worsened, and that even with extra sedatives his condition was unstable.

January 31, 2003 Incident with Patient R.L.

30. On January 31, 2003, Aragon was working on Ward F-5.

31. On that date, R.L. had been in remission for a period of two or three weeks. That morning, R.L. was responding to auditory hallucinations, and Aragon was aware of this.

32. After arriving at work for his 6:30 a.m. to 2:30 p.m. shift, Aragon accompanied the patients from Ward F-5 to the Recreation Center with Michele Audet, another staff member. R.L. approached Aragon and Audet and stated to Aragon that he was going to "give him a Sunday," meaning a sucker punch. Aragon did not think much of it at that time.

33. At approximately 10:30 a.m., Aragon accompanied the patients back to Ward F-5. Within a few minutes of their return, R.L. approached Aragon in the conference room and stated to Aragon, "Let's go outside, you and me." By this he meant to go outside and fight. Aragon asked R.L. to leave the area, which he did.

34. A few minutes later, R.L. returned to Aragon and again threatened him, stating, "Let's go outside, you and me." Aragon concluded that R.L. was focusing on him, was agitated, and that he needed additional medication to calm down.

35. Aragon then led R.L. to the nurses' station, where he informed a registered nurse, Tony Luna, that R.L. was agitated, was focusing on him, and needed a sedative to calm him down. Luna approved the medication.

36. At 10:45 a.m., Aragon administered 100 mg of Thorazine, a strong sedative, to R.L. As he did so, he talked to R.L. about the need to calm down. It would take the medication approximately 20 - 40 minutes to take effect.

37. After administering the medication to R.L., Aragon led him to the day hall on F-5 and told him to stay there. The day hall is a large open area where the patients usually sit and talk, watch television, read, or relax. Aragon left the area and went to the nurses' station. While there, he

noticed that CMHIP staff had not yet completed one of the room check-off sheets. He grabbed a clipboard and re-entered the day hall area.

38. While Aragon was standing in the day hall, approximately ten minutes after administering the Thorazine to R.L., R.L. snuck up on Aragon from behind, presenting a clear threat to Aragon. When Aragon discovered R.L. standing behind him, he walked away from him.

39. Aragon then started to walk down the hall on F-5. R.L. followed him and a second time snuck up on Aragon, presenting an even more serious threat. When Aragon turned around, R.L. had an angry look on his face. This time, Aragon concluded that R.L. actually intended to give him a sucker punch. Aragon felt very uncomfortable. He walked R.L. back to the day hall and told him to stay there.

40. At this moment, professional standards of conduct, which Aragon knew well, required him to avoid any further contact with R.L. for the duration of his shift. R.L. was agitated, had made three verbal threats to him that morning, and had snuck up on him twice, entering his zone of danger. Most troubling, the second time R.L. had snuck up on him, he had an angry look on his face.

41. Verbal Judo Step 1, Assess, required Aragon to avoid being drawn into an unsafe situation or environment. Further, CMHIP staff training mandated that Aragon be aware of the ward surroundings, constantly assess the situation, and, in the event a patient approaches, determine what that patient's body language tells him. Here, the angry look on R.L.'s face and his hostile behavior over the course of that morning were unmistakable signs of impending danger.

42. Had Aragon accurately assessed the situation and responded appropriately, in compliance with professional standards of conduct, he would have taken advantage of any of the following options that were available to him:

- make arrangements with Sharon Mondragon, Tony Luna, or Tom Shepard, the nursing supervisor, to complete the patient count on F-5, so that he could avoid R.L. for the duration of the shift;
- request that one of those staff members accompany him for the duration of his shift; or
- arrange for a staff person from Ward F-7, the adjacent unit, to trade units with him for the duration of his shift.

43. Aragon knew the location of other staff. They were nowhere in the vicinity he next chose to enter. He knew that Sharon Mondragon was in the nurses' station; Tony Luna, RN, was in the conference room meeting with a student; and Tom Shepard was in a room somewhere meeting with two other staff. None of these staff could see down the F-5 hall that Aragon chose to enter next.

44. After sneaking up on Aragon the second time, R.L. walked down the F-5 hall where the patient rooms (as well as other types of rooms) are located. It is a long, narrow hall. No other

staff could see down that hall.

45. Aragon followed R.L. down the hall, with M.T., another F-5 patient, accompanying him. They approached R.L., who was standing in front of them, approximately one third of the way down the hall. In doing so, Aragon chose to bring R.L. into his personal zone of danger, in direct violation of professional standards of conduct. Aragon was essentially asking for trouble.

46. Aragon stated to R.L., "How are you Robert?" R.L. assumed a fighting stance by putting his fists up in front of him, and stated to Aragon, "Come on!"

47. Professional standards of conduct at this moment again required that Aragon get away from R.L. immediately by walking or running away from him, out of the hall, and seeking other staff to take over for him on F-5 for the duration of his shift.

48. Instead of leaving the vicinity, Aragon responded to R.L., "I didn't do anything to you," and walked past R.L. further down the hall. In doing so, he further isolated himself from other staff.

49. R.L. followed Aragon and M.T., saying to Aragon, "I'm going to kick your ass," or words to that effect. Aragon responded, "Would you really like to kick my ass, Bobby?" Aragon told R.L. that he should come into the Patient Lounge, which was a dark room, to talk about his threat. He said, "Come on," or words to that effect. These actions by Aragon were a gross violation of professional standards.

50. R.L. then lunged at Aragon and began to attack him with closed fists.

51. Professional standards of conduct required Aragon to push R.L. away from him and run away, yelling for help. The One-Person Protective Restraint Technique prohibited Aragon from attempting to restrain R.L., due to the possibility of injury to both R.L. and Aragon: Aragon weighed 190 pounds; R.L. weighed 120 pounds.

52. Aragon responded to the attack by fighting back. He put his arms around R.L.'s legs or middle torso and pushed R.L. to the floor, tackling him. R.L.'s head hit the floor, which was made of cement. This "take down" of R.L. was not an approved means of subduing R.L.

53. Aragon attempted to restrain R.L. but was unsuccessful. R.L. fought hard, attempting to punch, kick, bite, and spit at Aragon. Aragon got on top of R.L., and placed his right forearm across R.L.'s left cheek and neck and held his head down as hard as he could. R.L. continued to try to lift his head up, attempting to bite and spit at Aragon, resulting in his head coming up and down from the floor repeatedly.

54. Once Aragon had R.L. on the floor, professional standards of conduct required that he run away from R.L. Aragon admitted on cross-examination at hearing that once R.L. was on the floor underneath him, he had the chance to run away, but did not.

55. Professional standards of conduct required Aragon to yell for assistance as soon as R.L. threw the first punch. Aragon never yelled for assistance during the altercation with R.L.

56. M.T., who witnessed the entire altercation, called for help. Tony Luna, RN, ran to the scene and found R.L. lying on his stomach with his arms to his sides, and Aragon on top, with his forearms on R.L.'s upper back. Next, Gene Ayala arrived, and found Aragon and Luna still trying to restrain R.L. Aragon, Luna, and Ayala then placed R.L. in a restraint, and brought him to a seclusion room. CMHIP staff cleaned R.L.'s wounds and later sent him to the medical clinic for further medical attention.

57. Aragon used excessive force in the altercation with R.L., causing serious injuries to R.L. Most notably, R.L. incurred an inch-long, deep, jagged cut above his right eye, requiring twelve stitches, and two smaller cuts below his left eye. In addition, he had dark red abrasions over large areas of his right shoulder, on his right upper back, and on the upper part of his right arm, and multiple scratches on the back of his neck and under his left cheek bone. At the time of the fight, R.L. was wearing thick prescription eyeglasses, which may have contributed to his injuries; by the end of the fight they had fallen off.

58. Significantly, R.L. did not have swelling or cuts on his fingers, indicating that he had not landed many, if any, of the punches he had thrown at Aragon.

59. Aragon sustained no visible injuries. He had no cuts, scratches or abrasions on his body. He had a fat lip immediately following the altercation, which healed that evening after application of ice. His right knee was very sore after the altercation, and has remained so for a period of months.

60. Veteran staff members at CMHIP have been involved in dozens, even hundreds, of takedown situations. One-on-one takedowns are extremely rare. By example, Aragon has been involved in only one other one-on-one takedown situation in his entire 22-year history there. No witness at hearing for either party had seen injuries on a patient after a takedown as serious as those sustained by R.L.

Competency and Credibility of C.D. and M.T.

61. Two patients on Ward F-5 were eyewitnesses to the altercation.[1] They are M.T., who as related above accompanied Aragon down the hall immediately preceding the altercation, and C.D. Both were committed to CMHIP upon adjudication as NGRI. Since these patients are presumptively incompetent to testify, a competency hearing was held. At the competency hearing, the Administrative Law Judge conducted voir dire of both patients, then permitted

1 A third, J.G., was not offered as a witness at hearing. Having been adjudicated NGRI, his statements to investigators were not admitted into evidence for the truth of the matters asserted.

counsel for both parties to ask additional questions.

62. Both C.D. and M.T. were competent to testify.

63. C.D. and M.T. were both highly credible witnesses. Their testimony at hearing was nearly identical to the statements each of them made independently to investigators following the January 31 altercation. Neither C.D. nor M.T. demonstrated bias for or against Aragon. Neither attempted to embellish his testimony.

64. The substance of C.D. and M.T.'s testimony was strikingly similar in a number of essential factual areas. Both testified clearly and without hesitation to the following:

A. As Aragon walked down the F-5 hall with M.T., Aragon and R.L. talked to each other prior to the physical altercation;
B. R.L. made another threat to Aragon, and Aragon responded, "I haven't done anything to you";
C. Aragon told R.L. they needed to talk it over, and indicated to R.L. that he should enter the Patient Lounge with him.

65. Neither C.D. nor M.T. appeared to have been aware that Aragon claimed not to have had a conversation with R.L. immediately preceding the attack.

Credibility of Aragon

66. Aragon is found not to be a credible witness. His sworn testimony at hearing often conflicted with his sworn testimony in deposition and his statements made to investigators immediately following the altercation. Further, he made conflicting sworn statements at hearing. Most striking, however, is how dramatically his version of the events in the F-5 hall immediately preceding the altercation differs from that of C.D. and M.T. Aragon asserts that when he walked down the F-5 hall with M.T., R.L. was not in the hall. He further asserts that as he approached the Patient Lounge, he did not speak with R.L. at all. Rather, he claims to have heard running footsteps behind him, and turned around to find R.L. attacking him, to his complete surprise. This testimony is given no weight.

Prior Corrective and Disciplinary Action

67. On January 19, 1999, Charles R. Bennett, Director of the Institute for Forensic Psychiatry, issued a Corrective Action to Aragon for purchasing cigarettes from a patient. The letter cited him for violating a CMHIP policy prohibiting conflict of interest situations with clients, which specifically bars the purchase of any item from a patient. Bennett characterized his misconduct as "a significant judgment error regarding professional boundaries."

68. On August 1, 1999, Bennett issued a disciplinary and corrective action to Aragon for violation of CMHIP's workplace violence policy. Aragon had lost his temper and engaged in an angry verbal altercation with another employee in front of co-workers and patients. In addition,

Aragon had acted in an intimidating manner towards another employee who was afraid to come to work. Bennett imposed a three month 5% decrease in pay.

Investigation

69. Per CMHIP policy, Tom Sheppard, RN II and supervisor on Ward F-5, contacted CMHIP police to report the January 31, 2003 assault by R.L. on Aragon. Captain Louis Archuleta assigned the investigation to Officer Mark Ramirez.

70. Officer Ramirez conducted a thorough and unbiased investigation of the incident. On the same evening of the altercation, he took pictures of R.L.'s injuries. The next day, he interviewed Sheppard, Aragon, Luna, Ayala, R.L., J.G., M.T., and two members of the nursing staff. On February 2, 2003, he issued a written report.

71. Irene Drewnicky, Assistant Superintendent of Clinical Services at CMHIP, Complainant's appointing authority, reviewed the police report and photographs of R.L.'s injuries. She was extremely concerned about the seriousness of R.L.'s injuries, as they far exceeded the injuries normally sustained by a patient in a takedown situation, as well as those of Aragon. She became concerned that Aragon had possibly used excessive force with R.L.

R-6-10 Pre-disciplinary Meeting

72. On February 26, 2003, Drewnicky held a pre-disciplinary meeting with Aragon and his union representative, and Linda Dotson, Chief Nurse on the forensic unit. Prior to the meeting, Drewnicky sent Aragon a copy of the police report for his review. Both Drewnicky and Aragon made independent tape recordings of the meeting.

73. The meeting lasted at least forty minutes, and Drewnicky and Dotson asked Aragon exhaustive questions regarding what had occurred on January 31, 2003, making their concerns about excessive force clear to him.

74. Aragon explained that R.L. had threatened him twice that morning, that he had given R.L. Thorazine; that R.L. then snuck up on him twice but was successfully redirected; and that as he took a step into the Patient Lounge, R.L. ran up behind him and attacked him. Drewnicky asked Aragon why he had not gone to inform other staff that R.L. was focusing on him. He responded that after he directed R.L. to the day hall, he had gone there.

75. Drewnicky showed him pictures of R.L.'s injuries and asked how he received certain ones. He responded that R.L. received the cut over his right eye when he hit his head on the floor after Aragon took him down. He also stated that he used his forearm to hold R.L.'s head and cheek down on the floor. He denied hitting R.L., and said he did not know how he incurred the other injuries.

76. When asked how R.L. sustained such serious injuries in such a short time, Aragon stated it

was from his being on top of him and struggling.

77. Drewnicky asked Aragon if he had had the chance to use any of the holds he had been taught in staff training. He responded that he had not.

78. At the meeting, Aragon gave Drewnicky copies of two letters of support from co-workers. Both letters state that patient M.T. is the more credible witness, as his mental status had been stable since his move to F5 and he had participated regularly in treatment. The letter states that patient J.G. (who had been in the Patient Lounge at the time of the altercation) had been psychiatrically unstable for several months, consistently responding to internal stimuli, and was openly delusional at times. They did not believe him to be a credible witness. They also stated that R.L. had been very unstable for the past month due to a death in the family and had been responding to internal stimuli on a regular basis.

79. In addition, Aragon's union representative read a statement concerning the work conditions on F5 that in his view led to the altercation. He stated that CTI training only every two years was insufficient to train staff to deal with an attack such as R.L.'s appropriately; and that lack of sufficient staff on the unit led to the unsafe situation.

80. Drewnicky asked Aragon if he had ever been accused of patient abuse in the past. He responded no, but if she found that he had, to let him know.

81. After the meeting, Drewnicky reviewed the police report again. She was struck by the discrepancy between Aragon's version of events and the eyewitness accounts of M.T., J.G., and R.L. himself. The police report contained the following description of M.T.'s statements to the officer: M.T. and Aragon were walking in the F-5 hall as Aragon was doing a ward check. While they were down the hall, R.L. was standing at the end of the hall. When they approached R.L., Aragon stated, "How are you R[.L.]?" R.L. assumed a fighting stance and stated to Aragon, "Come on!" Aragon then stated to R.L., "I didn't do anything to you," and walked away from R.L. Aragon then started to walk into the Patient Lounge, and informed R.L., who was right there, that they needed to talk about his threat. R.L. then attacked Aragon.

82. Based on the conflicting evidence before her, Drewnicky concluded she needed additional information. She visited Ward F-5, to view the area where the fight occurred. She met with the F-5 team leader, Yvonne Lopez and they walked the ward together. Then they met in Lopez's office and reviewed the photos of R.L.'s injuries. Lopez agreed with Drewnicky that the injuries appeared excessive.

83. Lopez informed Drewnicky that another patient on the hall, C.D., had come forward in a group therapy meeting to disclose he had witnessed the altercation, and was concerned about Aragon's conduct.

84. Drewnicky spoke with Dr. Jennings, the staff psychiatrist, and asked if it would be therapeutically acceptable for her to speak with C.D. Dr. Jennings said it would be fine.

Drewnicky showed Jennings the photographs and he felt R.L.'s injuries were excessive for the situation.

85. Drewnicky then met with C.D. C.D.'s version of events corroborated much of what M.T. had reported, as well as the statements of J.G. and R.L.

86. Based on this new information, Drewnicky called the CMHIP police and directed them to interview and obtain a statement from C.D. They did so, and attempted once again to interview Aragon, this time in the context of a supplemental investigation for potential patient abuse. Aragon requested that this second meeting with the investigator be tape-recorded. When the officer refused to do so, but informed Aragon that he could have an attorney present, Aragon elected not to speak to the officer.

87. Drewnicky then spoke with Anthony Pinelle, Chief Deputy of Public Safety at CMHIP, who presides over staff training there. In her discussion with Pinelle, she confirmed the following fundamentals in dealing with an agitated patient: avoid taking on a patient alone, in order to avoid injury to the patient and the staff worker; do not enter an isolated area by yourself with an agitated patient if there are no other staff in the vicinity; if a patient has already made repeated threats and is sneaking up on a staff member, the appropriate action is to avoid contact with that patient.

88. Drewnicky also asked Pinelle to provide her with copies of any past allegations of patient abuse against Aragon. There were two, both ultimately deemed to be unfounded.

89. She then reviewed CMHIP's policy defining patient abuse, its Code of Ethics, Aragon's personnel record, and his training record, determining that he had received and done well in all training in verbal judo and physical restraint techniques. Aragon's performance history indicates that he was a solid performer, receiving good to commendable scores on his evaluations. Supervisors have often noted as a strength his reliability in crisis intervention, and his strong staff/client working relationships.

90. In reviewing Aragon's two prior corrective and disciplinary actions, she was concerned that he had previously violated standards of maintaining a professional boundary with a patient, and had engaged in verbal altercations with other CMHIP staff, in front of patients.

91. Drewnicky noted that the extent and seriousness of R.L.'s injuries were unusual for a takedown. In a normal takedown situation, the injury is usually on one side of the body, which hits the floor when the patient is taken down. Neither she nor Pinelle had seen so many injuries before. Drewnicky concluded that Aragon had not used accepted physical control techniques, and that the dramatic disparity in injuries between R.L. and Aragon demonstrated that Aragon had used excessive force in the situation.

92. Drewnicky compared Aragon's version of events to those of the other eyewitnesses, M.T., C.D., and J.G. Deducing that it would be very difficult for three patients to have the same

delusion, she concluded that their version was far more credible than Aragon's. Aragon's version - that he was completely surprised by R.L.'s attack - so starkly contrasted with that of the patients that she did not believe it.

93. Drewnicky's lack of trust in Aragon's version of events led to her to ultimately determine that she could not trust him enough to place the CMHIP patients under his care again. She felt her overriding obligation was to the safety of the patients, who are dependant on CMHIP staff to assure their environment is safe. Even though patients become aggressive, staff still have an obligation to use the least restrictive force when patients' mental illnesses are manifested. She considered and rejected the idea of a demotion, because that would still involve placing Aragon back into a position of caring for the patients.

94. On March 10, 2003, Drewnicky sent a five-page termination letter to Aragon. The letter contained a number of findings, including the following:

A. Aragon failed to perform competently, demonstrated willful misconduct and misrepresented information to her;
B. Aragon engaged in patient abuse that adversely affects her trust in his future ability to perform his job safely and adequately;
C. He failed to notify co-workers of the situation. Had he secured the support and assistance of other staff, the entire event may have been prevented;
D. He never yelled for help, which is standard operating procedure for any take down or physical confrontation with a patient;
E. He failed to use standard and approved physical control techniques, which may have resulted in injury to the patient;
F. The physical injuries the patient sustained from Aragon appear to be as a result of excessive force for the containment of the patient;
G. Two witnesses and the patient victim indicate Aragon struck the patient's head on the floor, which suggests that he not only used excessive force, but intentionally harmed the patient;
H. His personnel record indicates that he had received two other corrective/disciplinary actions, one in August 1999 where he indicated he had a problem with his temper and his anger, and one in January 1999 for poor judgment in maintaining professional boundaries with a patient. Based on this record, she determined that she could not predict what she would do in the future based on his pattern of performance;
I. In the R-6-10 meeting, he stated he had never had allegations against him for patient abuse in the past. To the contrary, in April 1993 and June 1996 he had two formal allegations of abuse made against him, resulting in no action taken against him;
J. He violated the Code of Ethics;
K. He knowingly and willfully violated CMHIP Policy No. 16.15, Adult Patient Abuse/Neglect.

95. CMHIP Policy 16.15, Adult Patient Abuse/Neglect, provides, "It is the policy of CMHIP that all patients in its care and supervision shall be treated with dignity, courtesy and respect by

all employees. Each employee of CMHIP is expected to maintain a professional and therapeutic relationship with any patient." The policy defines patient abuse as "any behavior by an employee that is anti-therapeutic, non-professional and/or affects the patient detrimentally. Examples . . . include . . . striking a patient [and] using unnecessary force."

96. CMHIP's Code of Ethics provides in part, "Employees are expected to conduct business at CMHIP in a manner consistent with the mission of the hospital and the following principles: . . . Treat patients . . . with courtesy, dignity and respect . . . Maintain professional relationships and boundaries with patients and families, during and after patients' hospitalization."

DISCUSSION

I. Burden of Proof

Certified state employees have a property interest in their positions and may only be disciplined for just cause. Colo. Const. Art. 12, §§ 13-15; §§ 24-50-101, et seq., C.R.S.; *Department of Institutions v. Kinchen*, 886 P.2d 700 (Colo. 1994). Such cause is outlined in State Personnel Board Rules R-6-9, 4 CCR 801 and generally includes:

(1) failure to comply with standards of efficient service or competence;
(2) willful misconduct including either a violation of the State Personnel Board's rules or of the rules of the agency of employment;
(3) willful failure or inability to perform duties assigned; and
(4) final conviction of a felony or any other offense involving moral turpitude.

In this *de novo* disciplinary proceeding, the Respondent has the burden to prove by preponderant evidence that Aragon committed the acts or omissions on which the termination was based and that just cause warranted the termination. *Department of Institutions v. Kinchen*, 886 P.2d 700 (Colo. 1994). The Board may reverse Respondent's decision only if the action is found arbitrary, capricious or contrary to rule or law. Section 24-50-103(6), C.R.S.

II. Hearing Issues

A. Complainant committed the acts for which he was terminated.

Respondent has met its burden of proving that Aragon committed the acts for which he was disciplined. In closing argument, both parties conceded that the outcome of this case hinges on whether Aragon was surprised by R.L.'s attack, or whether he actively engaged R.L. immediately prior to the altercation. The preponderance of the evidence demonstrates that Aragon was not surprised by R.L.'s attack, but instead walked down the isolated hall directly towards R.L., whom he knew to be ready for a fight. Complainant violated CMHIP's patient abuse policy and its Code of Conduct by failing to maintain a professional boundary with R.L., and by using unnecessary force in an altercation that he could and should have avoided.

Complainant argues that because he successfully redirected R.L. so many times, R.L. never posed a threat, and therefore his actions were reasonable and did not violate professional standards of conduct. However, this argument ignores the evidence of the multiple, escalating and clear signs that R.L. was a danger to him. By failing to respond appropriately to those red flags, Complainant repeatedly violated the fundamental principles of the Continuum of Therapeutic Interventions. These CTI principles constitute standards of performance and conduct prescribed by CMHIP, to which all employees must adhere under section 24-50-116, C.R.S. ("Each employee shall perform his duties and conduct himself in accordance with generally accepted standards and with specific standards prescribed by law, rule of the board, or any appointing authority").

First, Complainant repeatedly failed to step back and assess the situation as it progressed. Second, he allowed himself to be drawn into R.L.'s taunting behavior and ultimately to become angry at R.L. Third, after R.L. snuck up on him a second time with an angry expression, he ignored this clear sign that it was time to vacate the premises and remove himself from any further contact with R.L. Fourth, when R.L. put up his fists and said, "Come on!", Complainant again chose to remain near R.L. and actually invited him into a dark, isolated room to "discuss his threat." This statement was akin to accepting R.L.'s offer to fight. Lastly, once R.L. threw the first punch, Complainant never yelled for help or ran away, instead opting to stay and win the fight. In the end, it appears that his inability to control his anger overcame him and he lost control over his behavior. His actions were not reasonable.

It has been asserted that the working conditions at CMHIP, specifically the lack of sufficient staff and training, are such that this type of incident could happen to any staff member at any time. However, for several reasons, the evidence demonstrates that the events of January 31 were unique. One-on-one takedowns such as this are extremely rare, indicating that most staff adhere to the requirement of either leaving unsafe situations or securing the aide of other staff members when warning signs are present. On January 31, the signs of danger were so clear that it is difficult to imagine another staff member responding in the same manner. Complainant's repeated and escalating breaches of professional standards of conduct created the unsafe situation, not a lack of training or staff. These standards of professional conduct are designed to protect the safety of CMHIP patients and staff, and this case demonstrates how critically important those standards are.

B. The Appointing Authority's action was not arbitrary, capricious, or contrary to rule or law.

Arbitrary or capricious exercise of discretion can arise in three ways, namely: (a) by neglecting or refusing to use reasonable diligence and care to procure such evidence as it is by law authorized to consider in exercising the discretion vested in it; (b) by failing to give candid and honest consideration of the evidence before it on which it is authorized to act in exercising its discretion; (c) by exercising its discretion in such manner after a consideration of evidence before it as clearly to indicate that its action is based on conclusions from the evidence such that reasonable men fairly and honestly considering the evidence must reach contrary conclusions. *Lawley v. Dep't of Higher Educ*., 36 P.3d 1239 (Colo. 2001).

Complainant contends that Drewnicky and the CMHIP police department conducted an

incomplete investigation that was arbitrary and capricious. He claims they erred in failing to consult the medical records of the patient eyewitnesses, in order to more accurately ascertain their competency and credibility. Standard practice at CMHIP is not to examine the medical records of patients that make statements for official investigations. In this case, all of the patients' statements were congruent. Drewnicky logically concluded that it would be impossible for all three of the patients to have the same delusion. The consistency of the statements was sufficient corroboration of the competency of their sources. Further, in this case M.T. was universally regarded by CMHIP staff and Aragon as competent, credible, and unbiased in his reporting on the events of January 31, 2003. Under these circumstances, Respondent did not act in an arbitrary or capricious manner in failing to review the medical records of the patient witnesses.

Complainant also asserts that as a veteran employee at CMHIP, having dedicated over twenty years to the patients there, he deserves another chance to prove himself. Complainant had a very strong therapeutic relationship with R.L. until January 31, 2003. He was generally a strong performer. The working conditions at CMHIP, where all staff are routinely subjected to abuse by patients, are incredibly challenging, and it is not difficult to have sympathy for Complainant's situation. However, unfortunately, because Complainant lacks credibility regarding the events of January 31, 2003, it would be irresponsible for hospital administrators to place him in a position of trust on the wards again. An appointing authority with ultimate responsibility for the care and safety of mental health patients simply cannot risk having an untrustworthy staff member, with a demonstrated history of losing his temper both verbally and physically at work, caring for patients. Drewnicky's decision was therefore a reasonable one.

C. Attorney fees are not warranted in this action.

Complainant has requested an award of attorney fees. Since Respondent prevailed, attorney fees and costs are not warranted.

CONCLUSIONS OF LAW

1. Complainant did commit the acts for which he was disciplined.

2. Respondent’s action was not arbitrary, capricious, or contrary to rule or law.

3. Attorney fees and costs are not warranted.

ORDER

Respondent’s action is **affirmed**. Complainant's appeal is dismissed with prejudice.

Dated this ___ day of August, 2003.

Mary S. McClatchey
Administrative Law Judge
1120 Lincoln Street, Suite 1420
Denver, CO 80203
303-764-1472

NOTICE OF APPEAL RIGHTS

EACH PARTY HAS THE FOLLOWING RIGHTS

1. To abide by the decision of the Administrative Law Judge ("ALJ").

2. To appeal the decision of the ALJ to the State Personnel Board ("Board"). To appeal the decision of the ALJ, a party must file a designation of record with the Board within twenty (20) calendar days of the date the decision of the ALJ is mailed to the parties. Section 24-4-105(15), C.R.S. Additionally, a written notice of appeal must be filed with the State Personnel Board within thirty (30) calendar days after the decision of the ALJ is mailed to the parties. Both the designation of record and the notice of appeal must be received by the Board no later than the applicable twenty (20) or thirty (30) calendar day deadline. Vendetti v. University of Southern Colorado, 793 P.2d 657 (Colo. App. 1990); Sections 24-4-105(14) and (15), C.R.S.; Rule R-8-58, 4 Code of Colo. Reg. 801. If the Board does not receive a written notice of appeal within thirty calendar days of the mailing date of the decision of the ALJ, then the decision of the ALJ automatically becomes final. Vendetti v. University of Southern Colorado, 793 P.2d 657 (Colo. App. 1990).

PETITION FOR RECONSIDERATION

A petition for reconsideration of the decision of the ALJ may be filed within 5 calendar days after receipt of the decision of the ALJ. The petition for reconsideration must allege an oversight or misapprehension by the ALJ. The filing of a petition for reconsideration does not extend the thirty-calendar day deadline, described above, for filing a notice of appeal of the decision of the ALJ.

RECORD ON APPEAL

The party appealing the decision of the ALJ must pay the cost to prepare the record on appeal. The fee to prepare the record on appeal is **$50.00** (exclusive of any transcription cost). Payment of the preparation fee may be made either by check or, in the case of a governmental entity, documentary proof that actual payment already has been made to the Board through COFRS.

Any party wishing to have a transcript made part of the record is responsible for having the transcript prepared. To be certified as part of the record, an original transcript must be prepared by a disinterested, recognized transcriber and filed with the Board within 45 days of the date of the designation of record. For additional information contact the State Personnel Board office at (303) 894-2136.

BRIEFS ON APPEAL

The opening brief of the appellant must be filed with the Board and mailed to the appellee within twenty calendar days after the date the Certificate of Record of Hearing Proceedings is mailed to the parties by the Board. The answer brief of the appellee must be filed with the Board and mailed to the appellant within 10 calendar days after the appellee receives the appellant's opening brief. An original and 7 copies of each brief must be filed with the Board. A brief cannot exceed 10 pages in length unless the Board orders otherwise. Briefs must be double-spaced and on 8 □ inch by 11-inch paper only. Rule R-8-64, 4 CCR 801.

ORAL ARGUMENT ON APPEAL

A request for oral argument must be filed with the Board on or before the date a party's brief is due. Rule R-8-66, 4 CCR 801. Requests for oral argument are seldom granted.

CERTIFICATE OF SERVICE

This is to certify that on the _____ day of August, 2003, I placed true copies of the foregoing **INITIAL DECISION OF ADMINISTRATIVE LAW JUDGE and NOTICE OF APPEAL RIGHTS** in the United States mail, postage prepaid, addressed as follows:

Mark Gerganoff
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P.O. Box 1477
29025-D Upper Bear Creek road
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and in the interagency mail, to:

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